DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED APR 15 1947

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 9781

Registration District No. 178 — Primary Registration District No. 3033 — Registrar's No.

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:

(a) County LACLEDE

(b) City or town LEBANON (If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: 620 WEST 5TH ST. (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution — (Specify whether In this community 50 YRS years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County LACLEDE 53

(c) City or town LEBANON (If outside city or town limits, write "RURAL") 1

(d) Street No. 620 W. 5TH ST (If rural, give location) 2

(e) Citizen of foreign country? NO (Yes or No) 0

If yes, name country

3. (a) PRINT FULL NAME MARY FRANCES CRABTREE

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex F 1

5. Color or race W

6. (a) Single, widowed, married, divorced WIDOW 2

6. (b) Name of husband or wife S.N. CRABTREE

6. (c) Age of husband or wife if alive years

7. Birth date of deceased OCT (Month) 2 (Day) 1868 (Year)

8. AGE: Years 78 Months 3 Days 9 If less than one day hr. min.

9. Birthplace COOPER CO (City, town, or county) MO (State or foreign country) 0

10. Usual occupation

11. Industry or business Housewife

FATHER
12. Name JAS. WELCHER
13. Birthplace (City, town, or county) U.S. (State or foreign country) 1

MOTHER
14. Maiden name not known
15. Birthplace (City, town, or county) (State or foreign country) 9

16. (a) Informant Geo. Williams

(b) Address LEBANON

17. (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 1-13-47 (Month) (Day) (Year)

(c) Place: burial or cremation ROCK DALE CEM.

18. (a) Signature of funeral director PALMER'S

(b) Address LEBANON

19. (a) April 5, 1947 (Date received local registrar) (b) Ora Frankeberger (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month JAN day 11 year 1947 hour 11 minute 45 A M.

21. I hereby certify that I attended the deceased from 1-5, 1947, to 1-11, 1947 that I last saw her alive on 1-11, 1947 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Chronic valvular heart disease	
Due to —	
Due to —	
Other conditions (Includes pregnancy within 3 months of death) Chronic glomerulo nephritis, bronchiectasis	

Major findings:
Of operations
Of autopsy

9 3 D

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify)

(b) Date of occurrence

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place)

While at work? (e) Means of injury 2

23. Signature Austin R. Knauss (M. D. or other) D.O.

Address Lebanon, Mo. Date signed 1/20/47

152 (Licensed Embalmer's Statement on Reverse Side)

Received 4/12/47

Laclede County Health Unit

File No. 1-47-54

Date Filed 4/14/47

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by ....., Registered Apprentice No. ..... working under my personal supervision.

Signed D O Palmer

Licensed Embalmer No. 116

P. O. Address Lebanon Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply w the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

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3-45
X43880

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. April

Registration District No. 170 Primary Registration District No. 3033 Registrar's No.

1. PLACE OF DEATH:
(a) County Laclede
(b) City or town Lebanon
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution (Specify whether years, months or days) In this community

2. USUAL RESIDENCE OF DECEASED:
(a) State (b) County
(c) City or town (If outside city or town limits, write "RURAL")
(d) Street No. (If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Mary J. Crabtree
3. (b) If veteran, name war
3. (c) Social Security No.

4. Sex F
5. Color or race W
6. (a) Single, widowed, married, divorced Wd
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive years
7. Birth date of deceased Oct 2 1868 (Month) (Day) (Year)

8. AGE: Years 78 Months 3 Days If less than one day hr. min.

9. Birthplace (City, town, or county) Mo (State or foreign country)
10. Usual occupation Housewife
11. Industry or business

FATHER
12. Name
13. Birthplace (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name
15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant
(b) Address
17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation
18. (a) Signature of funeral director
(b) Address
19. (a) (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April Day 1 year 1947 hour minute M.

21. I hereby certify that I attended the deceased from , 19 to , 19 ; that I last saw him alive on , 19 ; and that death occurred on the date and hour stated above.

Immediate cause of death — Duration
Due to
Due to
Other conditions (Include pregnancy within 3 months of death)
Major findings:
Of operations
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify)
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place)
While at work? (e) Means of injury

23. Signature (M. D. or other)
Address Date signed

SUPPLEMENTARY

9781